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person to perform them. The services must be related to patient care and be pertinent to the operation and sound management of the institution. Medicare definitions relating to ownership or control will apply. Total compensation to such persons must be listed and justified in Section E of the cost report. Where such amounts include items other than salaries, a schedule must be attached that identifies the amounts and the method of assigning values to these benefits. All such costs included in Section F must be reported in Section E. The Comptroller's Office will review these amounts, compare them with allowable compensation ranges, and make necessary adjustments. The Comptroller will utilize similar Medicare guidelines, salaries paid for comparable services in proprietary and nonproprietary institutions and any other information he considers relevant to future revisions of these ranges. The Comptroller will consider the duties, responsibility, and managerial authority of the person as well as the services performed for other institutions and his engagement in other occupations. Only one full-time position, or its equivalent, will be allowed to each person. The duties performed, time spent, and compensation received by such persons must be substantiated by appropriate records.

11. A return on net equity of no more than the amount allowed by Medicare for the cost reporting period shall be included as an allowable cost for proprietary providers, limited to $1.50 per patient day.

12. A one year trending factor shall be computed for facilities that have submitted cost reports covering at least six months of program operations. For facilities that have submitted cost reports covering at least three full years of program participation, the trending factor shall be the average cost increase over the three year period, limited to the 75th percentile trending factor of facilities participating for at least three years. Negative averages shall be considered zero. For facilities that have not completed three full years in the program, the one year trending factor shall be the 50th percentile trending factor of facilities participating in the program for at least three years. For facilities that have failed to file timely cost reports, the trending factor shall be zero.

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Using the trending factor determined above, each provider's allowable costs shall be trended from the mid-point of the provider's fiscal year to the mid-point of the state's fiscal year. Rates shall be re-established at the beginning of the state's fiscal year.

13. An incentive payment will be included in the reimbursable rate for providers who sufficiently contain costs as provided herein and maintain an average occupancy rate of 80% or greater. Certain expenses are fixed and not controllable on a day-to-day basis. These expenses include allowable rent, property taxes and insurance, depreciation, and interest. Total costs are determined for each provider and converted to a per patient day basis. Fixed costs are also determined for each provider and converted to a per patient day basis. Variable costs are determined by subtracting the fixed costs from the total costs. All intermediate care providers whose variable costs are less than the maximum reimbursement rate shall be eligible to receive a fifty percent (50%) cost containment incentive for every dollar they are below the maximum reimbursement rate, limited to three dollars ($3) per patient day and by the maximum reimbursement rate.

14. No carryover of allowable costs shall be allowed.

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15. Costs applicable to services, facilities and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall be required to identify related organizations and costs associated in the cost report.

B. Allowable Costs - Allowable costs shall include all items of expenses which providers must incur in order to:

1. Meet the definition of an intermediate care facility set forth in Section 279.10(b)(15) of Part 250, Chapter II, Title 45 of the Code of Federal Regulations and Title 42 CFR 447.150 of the Federal Regulations.*

2. Comply with the standards prescribed by the Secretary of the Department of Health, Education, and Welfare set forth in Federal Regulations.

3. Comply with requirements established by the State Department of Public Health, the State agency responsible for establishing and maintaining health standards, and

4. Comply with any other requirements for licensing under Tennessee State law which are necessary for providing intermediate care services, and

5. Furnish routine services as defined by the Department of Public Health, such definition shall, as a minimum, include all routine services defined as such by Federal Regulations.

C. Cost Reporting Requirements - Intermediate Care providers shall be required at their fiscal year end, or at other times as indicated by the State Comptroller of the Treasury, to submit to the Comptroller a cost report on forms designated by the Comptroller. This report shall be due three months from the end of the provider's designated fiscal period. A new provider entering the program may submit a budgeted cost report for six months or one year in order to obtain a per diem rate assigned by the Comptroller. This information will be compared with costs and other pertinent data of existing or other new providers to determine its reasonableness. This provider will then be required to submit actual cost reports at intervals designated by the Comptroller until the provider can be placed on its fiscal year reporting period. The cost report must be completed in accordance with the Medicare principles of cost reimbursement as stipulated in

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the Medicare Provider Reimbursement Manual, as updated, except as herein specified otherwise. In the event that the provider does not file the required cost report and other information by the first working day after the due date, the institution shall be subject to a penalty of ten dollars ($10.00) a day in accordance with state law.

D. Records Retention - Each provider of Level I care facility services is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health or the United States Department of Health and Human Services. All cost reports submitted by providers shall be retained by the State Comptroller of the Treasury for a period of not less than five years from the date of submission of the cost report.

E. Rates of Payment

1. Effective August 16, 1980, on July 1st of each succeeding year, or at such other times as it is deemed desirable, the Commissioner of the Department of Health, shall establish a program-wide maximum per diem payment level for Medicaid/TennCare facilities providing level I care. Effective for the period July 1, 1996 through September 30, 1996, the level I program-wide maximum is frozen at the rate in effect June 30, 1996. Effective July 1, 1997 through October 31, 1997, nursing facility rates are frozen at the rate in effect June 30, 1997. Effective November 1, 1997 new reimbursement rates will be set for the duration of the State's fiscal year for Medicaid/TennCare nursing facilities providing level I care. The expected per diem cost for each provider shall be the most recent per diem calculated adjusted to reflect changes for inflation , as described in Section II., Part A, Item 12 of this Plan. This level shall be the 50th percentile (effective July 1, 1990, the 65th percentile of facilities or beds, whichever is less) rounded to the nearest one cent, of the expected per diem cost of the providers who have had at least one cost report filed under the program when these providers are ranked from highest to lowest expected per diem cost. Effective October 1, 1996 capital-related costs are not subject to indexing. Effective August 16, 1980, the maximum per diem payment level for level I nursing facility services shall be the 50th percentile (effective July 1, 1990 the 65th percentile of facilities or beds, whichever is less) rounded to the nearest one cent of the adjusted, expected per diem costs, or the amount which would have been determined under Medicare Principles of Reimbursement, whichever is less. For State Fiscal Year 1996-97, the amount budgeted shall be the projected expenditures for State fiscal year 1995-96 plus 7 percent. A payout of approximately $8,500,000 will be issued for Medicaid/TennCare nursing facilities providing level I care in order to reimburse them the amount that would have been paid had the July 1, 1996 through September 30, 1996 freeze not been implemented. For State Fiscal Year 1997-98, the budgeted amount for level I and level II care is $672,040,000. Expenditures will be monitored throughout the year to determine if rate adjustments are necessary to assure that each level of care is spending within the budgeted amount. After analyzing final expenditures for the year, any savings from one level of care will be used to offset short falls from the other level of care. If any funds remain at the end of the year, those dollars will be used to provide additional funding to either level of care to reimburse them the amount that would have been paid had the July 1, 1997 through October 31, 1997 freeze not been implemented.

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Effective July 1, 1998, the Commissioner of the Department of Health shall establish a program-wide maximum per-diem payment rate for Medicaid/TennCare nursing facilities providing Level I nursing care. The maximum rate shall be established at such time(s) as deemed desirable by the Commissioner. The maximum per-diem rate shall be set at the 65th percentile cost of participating facilities or beds, which ever is lower, rounded to the nearest one cent. The rate of reimbursement, however, will be adjusted as necessary to assure that spending does not exceed the amount budgeted for each state fiscal year. Savings from one level of care will be used to offset any shortfalls from the other level of care.

2. The maximum per diem payment level for Intermediate Care Facilities-Mentally Retarded shall be reasonable allowable costs or charges, whichever is less. This level shall be the amount that the state reasonably expects to be adequate to reimburse in full such reasonable allowable costs of a facility that is economically and efficiently operated. The principles of cost determination for ICF-MR will be the same as a regular Level I nursing facilities, except that the Medicaid portion of mandated salary increases for state employees in state operated Intermediate Care Facilities for the Mentally Retarded (ICF-MR) shall be considered a pass-through payment for per diem rate and inflation factor computations. Such computations may be made effective with the annual per diem rate change based on the previous year cost report. Private for-profit and private not-for-profit intermediate care mental retardation facilities shall be reimbursed using the same prospective payment methodology as evel I nursing facilities except that reimbursement shall be at 100% of allowable Medicaid costs with no cost-containment incentive. Effective July 1, 1995, public intermediate care mental retardation facilities that are owned by government, shall be reimbursed 100% of allowable Medicaid costs with no cost-containment incentive. Reimbursement shall be based on Medicare principles of retrospective cost reimbursement with year-end cost report settlements. Interim per-diem rates for the fiscal year beginning July 1, 1995 and ending June 30, 1996 shall be established from budgeted cost and patient day information submitted by the government intermediate care mental retardation facilities. Thereafter, interim rates shall be based on the providers' cost reports. There will be a tentative year end cost settlement within 30 days of submission of the cost reports and a final settlement within 12 months of submission of the cost reports.

3. The maximum per diem payment made to each facility is per diem cost, charges or the maximum program-wide per diem rate, whichever is less.

4. If the resident has no resources to apply toward payment, the payment made by the state will be per diem cost, charges or the maximum program-wide per diem payment rate, whichever is less.

5. If the resident has resources to apply toward payment, the payment made by the state will be per diem costs less the available patient resources, charges less the available patient resources, or the maximum program-wide per diem payment rate less the available patient resources, whichever is less.

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6. Supplementary payments from relatives or others are not allowed.

7. The Tennessee Medicaid Program will pay to a provider of intermediate care services who furnishes in accordance with the requirements of this State Plan the amount determined for services furnished by the provider under the Plan.

8. Effective October 1, 1990, payment rates to providers of intermediate care services will take into account the costs to be incurred in meeting the requirements of Section 1919 (b), other than paragraph (3)(f), (c) and (d).

9. For state fiscal periods commencing on or after July 1, 1999, and subject to the availability of sufficient county, state and federal funds based upon an executed intergovernmental transfer agreement and subsequent transfer of funds, qualifying Medicaid level I nursing facilities shall receive a Medicaid nursing facility level I disproportionate share payment (M1DSA) one time each fiscal year.

(a) To be eligible to receive a (M1DSA) payment, a facility must be:
  (i) County owned, and
  (ii) Medicaid Level I and Level II covered days, from the facility's most recently filed Medicaid Level I cost report, must be equal to or greater than 75% of total facility patient days, and
  (iii) The facility must have more than 200 beds, and
  (iv) The facility must be the largest provider of Medicaid days in its county.

(b) For all facilities participating in the Medicaid Program, the Department of Finance and Administration shall determine a maximum upper payment limit in accordance with 42 CFR 447.272(a).

(c) Subject to the availability of funds the Department of Finance and Administration shall establish a pool of funds from which a disproportionate share payment will be made to eligible nursing facilities as described in section (a) above. The amount of the pool cannot exceed the upper payment limit described in section (b) above.

(d) Using the most recently filed cost report for each facility described in section (a) above, the Department of Finance and Administration shall determine each facility's (M1DSA) percentage by dividing the facility's Medicaid Level I days by the total number of Medicaid Level I patient days for all facilities described in section (a) above.

(e) Each eligible facility's (M1DSA) shall be determined by multiplying its (M1DSA) percentage by the total disproportionate share pool described in section (c).

(f) The Department of Finance and Administration shall verify that the Medicaid Level II patient days used to determine each facility's (M2DSA) percentage in section (d) above are as accurate as possible at the time of the calculation.

(g) Should subsequent review of the Medicaid Level II patient days included in the calculation described in section (d) above determine that inaccurate counts were used, the Department of Finance and Administration shall make a correcting adjustment on each facility's next (M2DSA) payment.

F. Cost Report Validation - Each cost report submitted in accordance with this Plan shall be audited by a Certified Public Accountant or a licensed Public Accountant, engaged by the provider, and shall include the auditor's report. Within six months after its submission to the Comptroller of the Treasury, each cost report will be desk reviewed to determine, where possible, a prospective per diem rate. When a desk review indicates that further audit review is desirable, the cost report will be designated to field audit. Each provider shall be allowed a minimum of 14 days to review and comment on the desk

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audit adjustments and the per diem rate proposed by the Comptroller of the Treasury before this per diem rate becomes effective. A field audit of the financial and statistical records of each participating provider will be performed over a three year period beginning January 1, 1977. During this period, no less than one third of the participating facilities are to be audited each year. Thereafter, on-site audits of the financial and statistical records will be performed each year in at least 15% of the participating facilities. At least 5% of these shall be selected on a random sample basis and the remainder shall be selected on the basis of the desk review or other exception criteria.

The audit program shall meet generally accepted auditing standards. This program shall provide procedures to verify the accuracy of the financial and statistical data on the cost report and to insure that only those expense items that this Plan has specified as allowable costs have been included by the provider.

Upon conclusion of each field audit of a nursing facility the Comptroller of the Treasury shall submit to the Department of Health and Environment a report of the audit. The audit report shall meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the cost report submitted by the provider is fairly stated. These audit reports shall be retained by the Department of Health and Environment for no less than five years. Overpayments to nursing facilities will be accounted for on form HCFA-64 no later than 60 days following the date of discovery.

G. Public Review and Comment - Interested members of the public will be granted an opportunity of at least thirty (30) days to review and comment on the proposed methods and standards of payment before they become effective.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
NURSING FACILITIES (NF)

Supplement to Attachment 4.19D

1. In compliance with OBRA 87, Tennessee assures that the ICF/SNF distinction in Nursing Facilities is abolished. All NF's participating in the Medicaid program must meet all applicable state and federal requirements in order to receive Medicaid reimbursement. NF's are reimbursed on the basis of one of two levels of patient acuity. Level 1 patients must have a medical condition that requires the availability of licensed nursing services on an inpatient basis twenty-four (24) hours each day of the week and must have a disability or impairment that renders them incapable of self-execution of needed nursing care and incapable of performance of at least one activity of daily living. Level 2 patients must have a medical condition that requires the delivery of a skilled nursing or rehabilitative service on a daily basis in an inpatient setting. (A skilled nursing service is defined as a licensed nursing service which is furnished to a person pursuant to a physician's order and which, because of the inherent complexity of the service, is such that it can only be safely and/or effectively provided directly by a registered nurse or licensed practical nurse.) Because of the complex medical needs of patients meeting Level 2 criteria, Level 2 NF care is reimbursed by Medicaid only in NF's that are certified by Medicare as well as by Medicaid for provision of nursing facility care.

   All references to "Intermediate Care Facilities" in Attachment 4.19D should be replaced with the designation "Level 1 NF Care." All references to "Skilled Nursing Facilities" in Attachment 4.19D should be replaced with the designation "Level 2 NF Care."

2. The additional costs of OBRA 87 are being accounted for in a pass-through payment to be paid initially for a period of nine months from October 1990 through June 1991, and for an additional period July 1, 1991 through June 30, 1992, after which NF rates will account for the costs of OBRA through the normal cost reporting and rate setting process.

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NURSING FACILITIES (NF)

Supplement to Attachment 4.19D Continued

The pass-through amount consists of $2.33 per day for nursing facilities formerly classified as ICF's and $1.90 per day for nursing facilities formerly classified as SNF's. The difference in these two figures, $.43, is needed by those nursing facilities formerly classified as ICF's in order to meet the RN staffing requirement.

Nurse aide training costs have also been analyzed and are projected to be $.05 per day for nursing facilities, beginning October 1, 1990. These costs will be paid in a separate pass-through amount as part of Medicaid administrative costs.

The methodology for determining the pass-through amount was as follows:

In November, 1989, the state formed a task force to work on identifying and quantifying the items mandated by OBRA 1987 for which nursing facilities would incur additional costs. The task force consisted of state and industry representatives. The task force identified nine such items which are: resident assessments, quality assessment committee, nurse aide training (which is to be accounted for as state administrative costs), RN staffing, social director, providing for "quality of life", drug reviews, inservice education, and rehabilitation. A comprehensive nursing home survey was prepared and sent to nursing facilities in December of 1989. The survey contained descriptions of the standards to be implemented (including a copy of the most recent resident assessment form available), as well as questions designed to assist the state in developing costs for the standards required by OBRA. Basic cost information submitted on the survey was for December 1989. However, where salary data was involved, amounts were increased to estimate the cost of payroll taxes and other benefits.

Tennessee validated the survey in May 1990 by picking a random sample of 14 nursing facilities and sending a team to visit each one. Staff at